Managed Care Resource Guide

Commonwealth of Virginia
Department of Medical Assistance Services

March 2010

Managed Care HelpLine
800-643-2273
TDD 800-817-6608

www.dmas.virginia.gov
ManagedCareHelp@dmas.virginia.gov
www.virginiamanagedcare.com
http://www.famis.org/

IMPORTANT: This is a reference guide only.
Information contained in this guide is subject to change without notice

MANAGED CARE RESOURCE GUIDE
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1. Overview of the Virginia Medicaid and FAMIS Program Delivery Systems

The Department of Medical Assistance Services (DMAS) administers the Medicaid and FAMIS Plus programs, in accordance with Title XIX of the Social Security Act. (FAMIS Plus is Virginia Medicaid's designation for its covered children.) DMAS also administers the Virginia Children's Health Insurance Program (CHIP), known as FAMIS (Family Access to Medical Insurance Security) under Title XXI of the Social Security Act. Medicaid and FAMIS programs are financed by Federal and State funds, administered by the State according to Federal and State guidelines, and are monitored closely by DMAS staff and the Centers for Medicare and Medicaid Services (CMS).

Medicaid Fee-For-Service and Managed Care Delivery Systems

DMAS provides Medicaid/FAMIS Plus coverage to individuals primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules; in accordance with Federal and State regulations; and as described in the applicable DMAS provider manuals. Provider Manuals are available on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx.

DMAS operates two Medicaid mandatory managed care programs in accordance with a CMS 1915(b) Managed Care Waiver, and in accordance with Federal and State Regulations. Within managed care, DMAS operates two distinctly different programs: 1) MEDALLION, a primary care case management program administered by DMAS; and, 2) Medallion II a program administered through contracted managed care organizations (MCO). These programs are more fully described in Sections 2 and 3 of this guide.

FAMIS Programs and Delivery Systems

DMAS operates 3 FAMIS benefits programs: 1) the FAMIS program for children under age 19; 2) FAMIS Select (a premium payment allowance for clients eligible for employer offered benefits); and, 3) FAMIS MOMS, coverage for FAMIS eligible pregnant women. Except for FAMIS Select, FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service. Additional information on all three FAMIS programs is provided in Section 4 of this guide.

Fee-for-Service (FFS)	
Program Name	**Description**
Medicaid Fee-for-Service	Standard Medicaid Program under Title XIX.
MEDALLION	A Title XIX Medicaid Managed Care Program utilizing contracted primary care case management (PCCM) providers in certain localities.
FAMIS (Family Access to Medical Insurance Security Plan)	A Title XXI Children's Health Insurance Plan (CHIP) and the CHIP Medicaid Expansion Program.

Managed Care Organizations (MCOs)	
Program Name	**Description**
Medallion II	A Title XIX Medicaid program, requiring mandatory participation for qualifying individuals, that utilizes contracted managed care organizations (MCOs).
FAMIS MCO (Family Access to Medical Insurance Security Plan)	Title XXI Children's Health Insurance Plan (CHIP) and the CHIP Medicaid Expansion Program utilizing contracted MCOs.

2. MEDALLION - A Primary Care Case Management (PCCM) Program

MEDALLION is a primary care case management (PCCM) program, where the enrollee's primary care physician (PCP) coordinates medically necessary care including referrals to specialty providers. Clients eligible for participation in MEDALLION will be assigned to a Primary Care Provider (PCP). MEDALLION PCPs are Medicaid-enrolled providers who have agreed to participate in MEDALLION and act as the "medical home" for clients assigned to their panel. The PCCM management fees and services for MEDALLION enrollees are reimbursed by DMAS in accordance with DMAS reimbursement rates and coverage guidelines.

Recipient Participation in MEDALLION

Non-institutionalized Medicaid recipients living within certain selected geographic areas are **MEDALLION eligible** in the following covered groups:

- Family and children-related groups; and
- Persons who are aged, blind, or disabled.

Some individuals in these groups are not MEDALLION eligible because they meet exclusionary criteria, as described below.

Exclusion from MEDALLION

In accordance with Title 12 of the Virginia Administrative Code at 12VAC30-120-280, individuals who meet any one of the following criteria will be excluded from MEDALLION participation:

a. Individuals who are inpatients in state mental hospitals and skilled nursing facilities, or reside in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or a long-stay hospital;
b. Individuals who are enrolled in §1915c home and community-based waivers, the family planning waiver, or the Family Access to Medical Insurance Security Plan (FAMIS);
c. Individuals who are participating in foster care or subsidized adoption programs, are members of spend-down cases, are refugees, or receive client medical management services;
d. Individuals receiving Medicare;
e. Individuals who are enrolled in DMAS-authorized residential treatment or treatment foster care programs;
f. Individuals whose coverage is retroactive only; and
g. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

A client may also be excluded from participating in MEDALLION if any of the following apply:

a. The client is not accepted to the caseload of any participating PCP.
b. The client's enrollment in the caseload of assigned PCP has been terminated, and other PCPs have declined to enroll the client.
c. The individual receives hospice services in accordance with DMAS criteria.

The Primary Care Provider – Medical Home

The Primary Care Provider (PCP) coordinates all medically necessary care for each patient enrolled in his or her MEDALLION panel of assigned clients. MEDALLION PCPs who accept children participate in the Vaccines for Children Program, the EPSDT Program (Early and Periodic Screening, Diagnosis and Treatment), and the Baby Care Program.

In addition to the DMAS Virginia Medicaid Provider Participation Agreement, the MEDALLION PCP must abide by the MEDALLION Provider Requirements. The MEDALLION PCP is paid a $3.00 monthly case management fee for each MEDALLION patient in his or her panel. PCPs receive a list monthly from DMAS that includes new and existing MEDALLION patients assigned to the PCP's practice.

MEDALLION PCP Referrals

The PCP may need a referral for a patient to go to specialty providers for medically necessary services. This authorization may be oral or written for a period appropriate to the illness. The PCP must document all referrals in the patient's medical record. The specialty provider must be enrolled in Virginia Medicaid to be reimbursed.

The following services **do not** require a PCP referral*

- Services provided by an OB/GYN
- Outpatient Psychiatric Services
- Family Planning
- Vision examinations for all clients
- Dental Services
- Immunizations and EPSDT (well child)
- School-Based Services
- Emergency Room Services
- Pharmacy Services
- Transportation
- Physician Inpatient visits
- Substance Abuse Treatment Services

**While reimbursement for these services does not require a PCP referral, prior authorization may be required. Also, as the "medical home" the PCP should be kept informed of all services the recipient receives to ensure efforts toward continuity of care and proper use of medical resources.*

REFERRALS TO ANOTHER PCP

- If a client is listed as a member of a PCP's panel for a given month, then the PCP must either see the patient or refer them to another PCP.
- The PCP, in an effort to provide health care, cannot penalize a patient for administrative issues.

REFERRALS TO SPECIALISTS

- The PCP, as the manager of care, is responsible for the judicious referral of a patient to a specialist.
- When a specialist is needed the PCP will refer his patient to any Medicaid enrolled specialist at his discretion.
- The PCP should document the referral in the patient's medical record, and specify the duration of the referral.

REFERRALS TO HOSPITALS

- The PCP must, under the MEDALLION contract, have admitting privileges to a hospital, or make arrangements to admit to hospitals in his or her area through other providers.
- Except for admissions from the Emergency Room, the **PCP referral is required for all inpatient admissions**.

*Additional information including the **MEDALLION SUPPLEMENT** and **the MEDALLION brochure** is available on the DMAS website at http://www.dmas.virginia.gov/ .*

MEDALLION CO-PAYMENTS

Services related to pregnancy, family planning, emergency or emergency room services are exempt from the co-pay requirement. There are no copayments for services to children under age 21. The Special Indicator Code (SI) notifies the provider of the recipient co-pay.

A – No co-pay under 21 years of age
B – No co-pay for any service. This applies to institutionalized or hospice patients.
C – Co-pay is required on certain services:

Doctor's office visit	$1.00	Home Health Visit	$3.00 per visit
Clinic Visit	$1.00	OT, PT, Speech	$3.00 per visit
Prescription Drugs	$1.00 generic	Other Doctor's Visit	$3.00
	$3.00 brand name	Outpatient Hospital Visit	$3.00 per visit
Eye Exam	$1.00 per exam	Inpatient Hospital Admission	$100.00

MEDALLION PRIMARY CARE PROVIDER REFERRAL FORM

Instructions for Use: This referral is valid only if authorized by the MEDALLION client's Primary Care Provider and is valid only for the services and duration specified. Should additional referrals be necessary, the Primary Care Provider must authorize the referral. Please provide the Primary Care Provider with full documentation of diagnosis, treatment, and/or therapies ordered.

Name of MEDALLION Patient: _____

MEDALLION ID #: _____

Today's Date: _____

Referred to: _____

Reason for Referral: _____

_____

_____

Number of Visits Authorized: _____

Time Frame of Authorization: _____

_____ _____
Signature of Primary Care Provider MEDALLION ID #

_____ _____
Printed Name of Primary Care Provider Telephone Number

_____
_____
_____
Address

3. Medallion II (Medicaid/FAMIS Plus MCO Program)

The Medallion II program is a fully capitated, risk-based, mandatory managed care program for Medicaid and FAMIS Plus individuals. Under Medallion II, DMAS contracts with managed care organizations (MCOs) for the provision of most Medicaid covered services. The contracted MCO receives a capitated per member per month (PMPM) payment that covers a comprehensive set of services, regardless of how much care is used by the recipient. Claims for Medallion II services are paid by the MCO in accordance with Federal and State guidelines as well as the MCO/provider negotiated contracts. In most areas of the Commonwealth, qualified Medicaid/FAMIS Plus recipients choose between at least two contracted Managed Care Organizations (MCO). In areas where only one contracted MCO participates, recipients have the choice between the MEDALLION PCCM and the Medallion II MCO program. There are currently 5 DMAS contracted MCOs: AMERIGROUP Community Care, Anthem HealthKeepers Plus, Optima Family Care, CareNet by Southern Health, and Virginia Premier Health Plan. As of November 1, 2009, MCOs operate in 114 Virginia localities with enrollment topping 481,000.

Recipient Participation in Medallion II

Not all Medicaid/FAMIS Plus* clients residing in a Medallion II region are eligible for enrollment in a MCO. Medallion II eligibles include non-institutionalized individuals in the following covered groups:

- Families and Children
- Aged, Blind, or Disabled

Some individuals in these groups are not Medallion II eligible because they meet exclusionary criteria, as described on the next page of this guide.

In order to see managed care eligible clients, providers must become part of the MCOs' networks and follow their rules and regulations.

Clients will receive most services through their MCO, and must follow the rules of that MCO for referrals, appointments, and other administrative requirements. By Contract, clients do not have to get referrals from their PCP for the following services:

- Immunizations
- Family Planning/OB/GYN services
- Mental health/mental retardation state plan option services
- School health services

The services listed below are "carved out" of the MCO contract and are covered and reimbursed by DMAS in accordance with DMAS program rules. Reference the chart in Section 14 of this guide for information on how to access carved out services.

- Community mental health rehabilitation services, mental retardation services, and substance abuse treatment services as set forth in 12 VAC 30-50-510 and 12 VAC 30-50-228, and 12 VAC 30-50-461
- School Health Services
- Targeted Case Management (except for high-risk maternity-infant targeted case management) i.e., MICC
- Investigations by local health departments to determine the source of lead contamination for children diagnosed with elevated blood lead levels, as set forth in 12 VAC 30-50-227
- Abortions as set forth in 12 VAC 30-50-180 and 42 CFR 441.203 and 441.206
- Specialized infant formula available through VDH WIC clinics and medical foods for enrollees under age 21 *(enteral equipment and supplies are covered through the child's MCO)*
- EPSDT Personal Care Services

Eligible clients can enroll in an MCO or obtain additional information by calling the Managed Care HelpLine at:
800-643-2273
(TTY/TDD 800-817-6608)
8:30 am – 6 pm, Monday through Friday
Detailed information is also provided at: www.virginiamanagedcare.com

**FAMIS Plus is the name for children's Medicaid. These individuals receive the same services as Medicaid recipients.*

Exclusion From Medallion II

In accordance with 12VAC30-120-370, the following individuals shall be excluded from participating in Medallion II. Individuals not meeting the exclusion criteria must participate in the Medallion II program.

1. Individuals who are inpatients in state mental hospitals;
2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded;
3. Individuals who are placed on spend-down;
4. Individuals who are participating in the family planning waiver, or in federal waiver programs for home-based and community-based Medicaid coverage prior to managed care enrollment;
5. Individuals who are participating in foster care or subsidized adoption programs;
6. Individuals under age 21 who are either enrolled in DMAS authorized treatment foster care programs as defined in 12VAC30-60-170 A, or who are approved for DMAS residential facility Level C programs as defined in 12VAC30-130-860;
7. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (e.g., physician, hospital, midwife) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;
8. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;
9. Individuals who receive hospice services in accordance with DMAS criteria;
10. Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);
11. Individuals requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time of MCO enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion reason shall not apply to recipients admitted to the hospital while already enrolled in a department-contracted MCO;
12. Individuals who request exclusion during preassignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The client's physician must certify the life expectancy;
13. Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment;
14. Individuals who have an eligibility period that is less than three months;
15. Individuals who are enrolled in the Commonwealth's Title XXI SCHIP program;
16. Individuals who have an eligibility period that is only retroactive; and
17. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

Individuals enrolled with a MCO who subsequently meet one or more of the aforementioned criteria during MCO enrollment shall be excluded from MCO participation as determined by DMAS, with the exception of those who subsequently become recipients in the federal long-term care waiver programs, as otherwise defined elsewhere in this chapter, for home-based and community-based Medicaid coverage (AIDS, IFDDS, MR, EDCD, Day Support, or Alzheimers, or as may be amended from time to time). These individuals shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

Individuals excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

** Historically, individuals enrolled in a HCB Waiver were disenrolled and/or were not eligible to participate in the Department's MCO program. However, effective September 1, 2007, MCO enrolled individuals who become enrolled in a HCB waiver (except for the Technology Assisted Waiver) will remain enrolled in their assigned MCO for medical services and transportation to medical appointments. The individual's HCB services (including transportation to HCB services) are managed and paid for under the DMAS fee-for-service program. MCO individuals who become enrolled in the Technology Assisted Waiver continue to be disenrolled from the MCO. This solution avoids disruption to medical client/provider relationships and enables better coordination between acute and long-term care services.*

4. Family Access to Medical Security Insurance (FAMIS) Program

FAMIS

FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service (through DMAS). Like Medallion II, the FAMIS MCO program also operates under a risk-based capitated PMPM payment contract. DMAS contracted MCOs for FAMIS are the same as those contracted with DMAS for Medallion II.

In most areas of the state, FAMIS enrollees have the choice between 2 or more MCOs. In areas where only one MCO participates, the enrollee receives care through the MCO. FAMIS enrollees are not eligible for the MEDALLION program. In areas where MCOs are not available, FAMIS benefits are administered by DMAS fee-for-service.

FAMIS benefits are slightly different from the benefits under Medicaid (i.e., through MEDALLION, Medallion II and Medicaid fee-for-service). **(**Reference the covered services grid in Section 14 of this guide for a detailed listing of covered services.) There are benefit limitations and small co-payments much like those associated with commercial group health insurance.

The following services (while covered under Medicaid) are not covered under FAMIS:

- EPSDT services – Early and Period Screening Diagnosis and Treatment services, is not a covered service under FAMIS. However, many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS' well child and immunization benefits.
- Psychiatric Treatment in free standing facilities is not covered (but is covered when provided in a psychiatric unit of an acute hospital)
- Routine transportation – to and from medical appointments is not covered. (Exception: Children living in non-managed care areas may receive non-emergency transportation services.) Emergency transportation is covered.
- Temporary Detention Orders (TDOs) are not covered.

FAMIS MOMS

FAMIS MOMS provides enrollees the same coverage that pregnant women currently receive from the Virginia Medicaid program. FAMIS MOMS expands this coverage to include pregnant women with family incomes over 133% but less than or equal to 185% of the Federal Poverty Level (FPL). There is no difference in covered services, service limitations, and pre-authorization requirements. FAMIS MOMS use the same health care services delivery system (fee for service or managed care organizations) as FAMIS. There are no co-pays for pregnancy related services. Babies born to FAMIS MOMS are not automatically covered. *The parent/guardian must make application for Medicaid or FAMIS on behalf of the FAMIS MOMS newborn*.

FAMIS Select

FAMIS *Select* is a program that gives parents of FAMIS enrolled children the freedom to choose between covering their children with the FAMIS health insurance plan or with a private or employer's health plan. FAMIS *Select* gives parents that choose to purchase private or employer sponsored health insurance $100 per child per month to help pay the child's part of the premium. In some cases, a private or employer plan may give a family more choice of providers. For some families, the FAMIS *Select* payment will be enough to make health coverage affordable for the entire family.

FAMIS Central Processing Unit

Families may call the FAMIS Central Processing Unit (1-866-873-2647), their local DSS, or a Local Outreach Assistance Project for questions pertaining to FAMIS eligibility. To check on the status of a FAMIS application, families should contact the place at which they applied for FAMIS benefits.

For the most up-to-date information on FAMIS, visit the FAMIS website at: http://www.famis.org/.

FAMIS Cost Sharing

Under FAMIS there are no enrollment fees or monthly premiums. Services rendered to FAMIS children in MCOs except well-child, preventive care and immunization services, require co-payments from the enrollee. FAMIS co-payments are typically $2 or $5 depending on income for most services. The table below provides more detail on copayments by type of service. Cost sharing cannot exceed $180 per family per calendar year if a family's gross income is less than 150 percent of the federal poverty level and $350 per family per calendar year if gross income is more than 150% of the federal poverty level. No cost sharing is charged to American Indian and Alaska Native children.

Copayment By Type of Service		
Type of Service	**<150%**	**>150%**
Inpatient Services (Per Confinement) (Acute, Rehab, Psychiatric, Substance Abuse)	$15	$25
Hospital ER (Emergent per Prudent Layperson)	$2	$5
Skilled Nursing Facility	$15	$25
ER Physician Charges (Emergent per Prudent Layperson)	$2	$5
Non-Emergency use of ER	$10	$25
Well Child Care, Immunizations, Lead Testing	$0	$0
Physician (Primary, Specialty, Maternity) *Pap Smears require no co-pay* *Physician Inpatient requires no co-pay*	$2	$5
Outpatient Services (Medical, Mental Health, and Substance Abuse Treatment Services)	$2	$5
Chiropractic (coverage is limited to 500 per calendar year)	$2	$5
Therapy (PT, OT, Speech)	$2	$5
Early Intervention (Coverage through DMAS Fee-For-Service)	$0	$0
Hospice	$0	$0
Home Health and Private Duty Nursing	$2	$5
Other Services (Family Planning, Emergency Transportation, Hearing Aids, Lab and X-ray, Durable Medical Equipment*, Prosthetics/ Orthotics) **Supplies require no copayment*	$2	$5
Second Opinions	$2	$5
Organ Transplants Facility Out Patient *Donor identification Services - limited to $25,000 per member)*	 $15 $2	 $25 $5
Prescription Drugs Retail, up to 34 day supply Retail 35 – 90 day supply Mail service up to 90 day supply	 $2 $4 $4	 $5 $10 $10
*(If a generic is available, enrollee pays co-payment **plus** 100% of the difference between the allowable of the generic drug and the brand drug.)*		
Vision Services Routine eye exam (one per 24 months)	 $2	 $5
Annual Co-Payment Limit	**<150%**	**>150%**
Calendar Year Limit / Per Family	**$180 per family**	**$350 per family**
Plan pays 100% of allowable charge once limit is met for covered services.		

5. Verifying Eligibility and Enrollment (MCO or FFS)

All providers of services must verify program eligibility at each visit. Medicaid/FAMIS Plus and FAMIS eligibility can change. Relying on the permanent plastic card or even a newly issued MCO card does not guarantee current eligibility or reimbursement. Providers should know the payer source before services are rendered.

DMAS offers a web-based internet option to access information regarding Medicaid and FAMIS eligibility called the Automated Response System (ARS). The MediCall voice response system will provide the same information by telephone. Both options are available at no cost to the provider.

Automated Response System (ARS) – Web-based Internet Eligibility Verification

ARS is a web-based, HIPAA-compliant verification system that provides information regarding Medicaid and FAMIS eligibility and enrollment information. In addition, providers can utilize ARS for verifying claims status, check status, service limits, prior authorization, pharmacy prescriber identification information, as well as MCO and MEDALLION PCP enrollment information. The website address to enroll in this system is: http://virginia.fhsc.com.

MediCall

Providers call MediCall at **800-884-9730 or 800-772-9996** to verify eligibility. The MediCall line will give recipient eligibility, special indicator codes, Managed Care Program assignment (including coverage dates), the MEDALLION PCP (as applicable) including phone number, or MCO provider name.

MediCall is operational 24 hours a day 365 days a year. Although MediCall is designed to be accessed by touch-tone phone, dial phone may be used. A live operator is available 8:30 a.m. to 4:30 p.m.

Information required to use MediCall includes your Medicaid Provider ID/NPI number, the Recipient Medicaid ID number OR the Social Security Number and date of birth, and the From and Through date(s) of service--a single date or dates spanning not more than 31 days. Providers also may make reimbursement check status inquiry and claims status inquiry from the most recent three remittances.

6. Managed Care Helpline

The Managed Care Helpline (MC Helpline) is a toll-free (1-800-643-2273 and TDD# 1-800-817-6608) customer service call center, available to MEDALLION and Medallion II *eligible or enrolled* individuals. The MC Helpline provides detailed information about managed care primarily to assist clients in making an informed decision about the most appropriate MCO (or PCP for MEDALLION) to meet their health care needs. The MC Helpline operates from 8:30 AM to 6:00 PM, Monday through Friday except on State holidays.

The functions of the Managed Care Helpline include, but are not limited to:

- Enrolling clients into an MCO or PCP, initially or as a change.
- Educating clients about managed care and health plans in their area.
- Assisting clients with the resolution of health care issues, tracking client complaints, and providing complaint information to DMAS.
- Triaging of telephone calls to participating health plans, member services departments, local DSS agencies or the Department's recipient and provider helplines.
- Completing health status assessments (HSA) on new members and forwarding information to the participating MCO that the member has selected.

Functions excluded from the Managed Care Helpline include, but are not limited to:

- Entering or modifying client eligibility information such as name, address, telephone number, date of birth, FIPS code, Aid Category, etc. This is a function of the local Department of Social Services (DSS).
- Verification of eligibility requests: DMAS has mechanisms for providers to verify client eligibility including the Audio Voice Response System (AVRS), formerly called the REVS line, and the DMAS web based system. The MCOs also provide assistance to verify their member eligibility.

Information on Managed Care, including details on how to enroll, open enrollment, MCOs available by locality, etc., is also available on the Managed Care Helpline website at www.virginiamanagedcare.com .

HEALTH STATUS SURVEY QUESTIONNAIRE

I would like to ask you some questions about your health and the health of any other MCO members in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new members so they can begin planning for your care. Do you have a minute to answer these questions?

Some of these questions are personal, and your answers will be confidential and private—only the MCO will get this information.

Please answer for yourself and everyone in your house who is a member of the MCO.

Case Head:	Case Head SSN:		Case Head Language:
Last Name	First Name		Medicaid ID#
Address	City	State/Zip	Ph#

1.	Gender	☐ Male ☐ Female
2.	Date of Birth	
3.	What MCO are you choosing?	Name:
4.	Do you have a doctor you want to be your Primary Care Provider?	Name:
5.	If you have a regular doctor now, what is the doctor's name?	Names:
6.	Are you seeing any specialists (doctors who specialize in a particular field of medicine, such as a cardiologist)? [If yes] What are the names?	☐ Yes ☐ No List:
7.	Are you taking medicines that a doctor has prescribed? [If yes, ask what they are and what they're for.]	☐ Yes ☐ No List:
8.	Are you using any durable medical equipment, such as a hospital bed, oxygen, a wheelchair, a breathing machine—anything like that? If yes, did a doctor prescribe it?	☐ Yes ☐ No What: ☐ Yes ☐ No
9.	Are you pregnant? [If yes], ▪ When is the baby due? ▪ Does the doctor have any special concerns about this pregnancy?	☐ Yes ☐ No Date:

Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.

10.	Do you have surgery planned for the future? If yes, what is the date of surgery?	☐ Yes ☐ No Date:
11.	Are you getting home care or home hospice care? If yes, please explain.	☐ Yes ☐ No Explanation:
12.	Are you on an organ transplant list? If yes, please explain.	☐ Yes ☐ No Explanation:
15.	Are you getting physical therapy, or occupational therapy, or speech therapy?	☐ Yes ☐ No
16.	Do you have a heart condition— such a congestive heart failure?	☐ Yes ☐ No

HEALTH STATUS SURVEY QUESTIONNAIRE (Continued)		
17.	Do you have a lung disorder—such as asthma or COPD?	☐ Yes ☐ No
18.	Are you being treated by a psychiatrist or psychologist?	☐ Yes ☐ No
19.	Do you have diabetes?	☐ Yes ☐ No
20.	High blood pressure?	☐ Yes ☐ No
21.	Do you have kidney disease or are you on dialysis?	☐ Yes ☐ No
22.	Do you have cancer?	☐ Yes ☐ No
23.	Do you smoke?	☐ Yes ☐ No
24.	Are you living with HIV or AIDS?	☐ Yes ☐ No
25.	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	☐ Yes ☐ No
26.	Do you have tuberculosis (TB)?	☐ Yes ☐ No
27.	Is there a child in the house in ▪ Part C services, care coordination for children ▪ any health department program, or Does any child receive Case Manager or Care Coordinator services?	☐ Yes ☐ No List program and/or care coordinator:
28.	Can you think of any other special medical or mental health needs that the MCO might want to know about?	☐ Yes ☐ No List:
29.	Have you been in the hospital in the last 12 months? [If yes] Why were you admitted?	☐ Yes ☐ No Reason:
30.	What is your height?	feet_____ inches_____
31.	And your weight?	Pounds

Thank you for taking the time to answer these questions. I'll give this information to your new MCO, and they will be in touch with you soon.

If you have any questions or need assistance, please call the Managed Care Help Line at 1-800-MGD-CARE or 1-800-643-2273.

7. Medallion II and MEDALLION Open Enrollment Effective Dates

*****NOTE: THESE OPEN ENROLLMENT PERIODS DO NOT APPLY TO FAMIS*****

CENTRAL VIRGINIA REGION **LETTERS MAIL LATE JANUARY. RECIPIENTS CALL FEBRUARY AND MARCH. CHANGES EFFECTIVE APRIL 1**					
001	ACCOMACK	081	GREENSVILLE	133	NORTHUMBERLAND
007	AMELIA	085	HANOVER	135	NOTTOWAY
025	BRUNSWICK	087	HENRICO	730	PETERSBURG
033	CAROLINE	670	HOPEWELL	145	POWHATAN
036	CHARLES CITY	097	KING AND QUEEN	147	PRINCE EDWARD
041	CHESTERFIELD	099	KING GEORGE	149	PRINCE GEORGE
570	COLONIAL HEIGHTS	101	KING WILLIAM	760	RICHMOND CITY
049	CUMBERLAND	103	LANCASTER	159	RICHMOND CO.
053	DINWIDDIE	111	LUNENBURG	175	SOUTHAMPTON
595	EMPORIA	115	MATHEWS	177	SPOTSYLVANIA
057	ESSEX	117	MECKLENBURG	179	STAFFORD
620	FRANKLIN CITY	119	MIDDLESEX	181	SURRY
630	FREDERICKSBURG	127	NEW KENT	183	SUSSEX
075	GOOCHLAND	131	NORTHAMPTON	193	WESTMORELAND
TIDEWATER REGION **LETTERS MAIL LATE APRIL. RECIPIENTS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1**					
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	735	POQUOSON	830	WILLIAMSBURG
093	ISLE OF WIGHT	740	PORTSMOUTH	199	YORK
095	JAMES CITY CO.				
NORTHERN, AND WINCHESTER REGIONS **LETTERS MAIL LATE JUNE. RECIPIENTS CALL JULY AND AUGUST. CHANGES EFFECTIVE SEPTEMBER 1**					
510	ALEXANDRIA	059	FAIRFAX CO.	683	MANASSAS CITY
013	ARLINGTON	610	FALLS CHURCH	685	MANASSAS PARK
043	CLARKE	061	FAUQUIER	153	PRINCE WILLIAM
600	FAIRFAX CITY	107	LOUDOUN	139	PAGE
157	RAPPAHANNOCK	069	FREDERICK	840	WINCHESTER
171	SHENANDOAH	187	WARREN		
NEAR SOUTHWEST AND WEST REGIONS **LETTERS MAIL LATE AUG. RECIPIENTS CALL SEPT. AND OCT. CHANGES EFFECTIVE NOVEMBER 1**					
003	ALBEMARLE	065	FLUVANNA	137	ORANGE
009	AMHERST	067	FRANKLIN CO.	141	PATRICK
011	APPOMATTOX	071	GILES	143	PITTSYLVANIA
015	AUGUSTA	079	GREENE	155	PULASKI
515	BEDFORD CITY	083	HALIFAX	750	RADFORD
019	BEDFORD CO.	660	HARRISONBURG	770	ROANOKE CITY
023	BOTETOURT	089	HENRY	161	ROANOKE CO.
029	BUCKINGHAM	678	LEXINGTON	163	ROCKBRIDGE
530	BUENA VISTA	109	LOUISA	165	ROCKINGHAM
031	CAMPBELL	680	LYNCHBURG	775	SALEM
037	CHARLOTTE	113	MADISON	790	STAUNTON
540	CHARLOTTESVILLE	690	MARTINSVILLE	820	WAYNESBORO
590	DANVILLE	121	MONTGOMERY	197	WYTHE
063	FLOYD	125	NELSON		
MEDALLION OPEN ENROLLMENT **LETTERS MAIL LATE NOV. RECIPIENTS CALL DECEMBER AND JANUARY. CHANGES EFFECTIVE FEBRUARY 1**					
005	ALLEGHANY	077	GRAYSON	191	WASHINGTON
017	BATH	091	HIGHLAND	195	WISE
021	BLAND	105	LEE	520	BRISTOL
027	BUCHANAN	167	RUSSELL	580	COVINGTON
035	CARROLL	169	SCOTT	640	GALAX
045	CRAIG	173	SMYTH	720	NORTON
051	DICKENSON	185	TAZEWELL		

8. Medallion II/FAMIS MCO Participation By Locality

Participation by locality as of 12/01/2009

CITY/COUNTIES	FIPS	Anthem (HealthKeepers, Peninsula or Priority)	Virginia Premier Health Plan	Optima Family Care	CareNet	AMERIGROUP
ACCOMACK	001	X	X	X		
ALBEMARLE	003	X	X	X	X	
AMELIA	007	X	X	X	X	
AMHERST	009		X	X	X	
APPOMATTOX	011		X	X	X	
ARLINGTON	013	X				X
AUGUSTA	015		X	X	X	
BEDFORD COUNTY	019		X			
BOTETOURT	023		X			
BRUNSWICK	025	X	X	X		
BUCKINGHAM	029	X	X	X	X	
CAMPBELL	031		X	X	X	
CAROLINE CO	033	X		X	X	
CHARLES CITY	036	X	X	X	X	
CHARLOTTE	037		X	X		
CHESTERFIELD	041	X	X	X	X	
CLARKE	043	X	X	X		
CULPEPER	047					X
CUMBERLAND CO	049	X	X	X	X	
DINWIDDIE	053	X	X	X	X	
ESSEX	057	X		X	X	
FAIRFAX COUNTY	059	X				X
FAUQUIER	061	X				X
FLOYD	063		X			
FLUVANNA	065	X	X	X	X	
FRANKLIN COUNTY	067		X			
FREDERICK	069	X	X	X		
GILES	071		X			
GLOUCESTER	073	X		X		
GOOCHLAND	075	X	X	X	X	
GREENE	079	X	X	X	X	
GREENSVILLE	081	X	X	X		
HALIFAX	083	X	X	X		
HANOVER	085	X	X	X	X	
HENRICO	087	X	X	X	X	
HENRY	089		X			
ISLE OF WIGHT	093	X		X		
JAMES CITY CO	095	X		X		
KING & QUEEN	097	X		X	X	
KING GEORGE CO	099	X	X			
KING WILLIAM	101	X	X	X	X	
LANCASTER	103			X	X	
LOUDOUN	107	X				X
LOUISA	109	X	X	X	X	
LUNENBURG CO	111	X	X	X	X	
MADISON	113	X		X		X
MATHEWS	115	X		X	X	
MECKLENBURG CO	117	X	X	X	X	
MIDDLESEX	119	X		X	X	
MONTGOMERY	121		X			
NELSON	125	X	X	X	X	
NEW KENT	127	X	X	X	X	
NORTHAMPTON	131	X	X	X		

Medallion II/FAMIS MCO Participation By Locality

Participation by locality as of 12/01/2009

CITY/COUNTIES	FIPS	Anthem (HealthKeepers, Peninsula or Priority)	VA Premier Health Plan	Optima Family Care	Care*Net*	AMERIGROUP
NORTHUMBERLAND	133	X		X	X	
NOTTOWAY	135	X	X	X	X	
ORANGE	137	X		X	X	X
PAGE	139	X	X	X		
PATRICK	141		X			
PITTSYLVANIA	143		X	X		
POWHATAN	145	X	X	X	X	
PRINCE EDWARD	147	X	X	X		
PRINCE GEORGE	149	X	X	X	X	
PRINCE WILLIAM	153	X				X
PULASKI	155		X			
RAPPAHANNOCK	157	X		X		X
RICHMOND COUNTY	159	X		X	X	
ROANOKE COUNTY	161		X			
ROCKBRIDGE	163		X			
ROCKINGHAM	165		X	X		
SHENANDOAH	171	X	X	X		
SOUTHAMPTON	175	X	X	X		
SPOTSYLVANIA CO	177	X	X			
STAFFORD CO	179	X	X			
SURRY	181	X	X	X	X	
SUSSEX	183	X	X	X	X	
WARREN	187	X		X		
WESTMORELAND CO	193	X	X	X	X	
WYTHE	197		X			
YORK	199	X		X		
ALEXANDRIA	510	X				X
BEDFORD CITY	515		X			
BUENA VISTA	530		X			
CHARLOTTESVILLE	540	X	X	X	X	
CHESAPEAKE	550	X	X	X		
COLONIAL HEIGHTS	570	X	X	X	X	
DANVILLE	590		X	X		
EMPORIA	595	X	X	X		
FAIRFAX CITY	600	X				X
FALLS CHURCH	610	X				X
FRANKLIN CITY	620	X	X	X		
FREDERICKSBURG	630	X	X			
HAMPTON	650	X	X	X		
HARRISONBURG	660		X	X		
HOPEWELL	670	X	X	X	X	
LEXINGTON	678		X			
LYNCHBURG	680		X	X	X	
MANASSAS CITY	683	X				X
MANASSAS PARK	685	X				X
MARTINSVILLE	690		X			
NEWPORT NEWS	700	X	X	X		
NORFOLK	710		X	X		
PETERSBURG	730	X	X	X	X	
POQUOSON	735	X		X		
PORTSMOUTH	740		X	X		
RADFORD	750		X			
RICHMOND CITY	760	X	X	X	X	

Medallion II/FAMIS MCO Participation By Locality

Participation by locality as of 12/01/2009

CITY/COUNTIES	FIPS	Anthem (HealthKeepers, Peninsula or Priority)	VA Premier Health Plan	Optima Family Care	CareNet	AMERIGROUP
ROANOKE CITY	770		X			
SALEM	775		X			
STAUNTON	790		X	X	X	
SUFFOLK	800	X	X	X		
VIRGINIA BEACH	810	X	X	X		
WAYNESBORO	820		X	X	X	
WILLIAMSBURG	830	X		X		
WINCHESTER	840	X	X	X		

9. Member Services Contact Information

Plan Name	Member Services Phone Number
AMERIGROUP Community Care	1-800-600-4441 TTY 1-800-855-2880 www.myamerigroup.com
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority)	1-800-901-0020 Nurse Advice Line (24/7 NurseLine) – 1-800-382-9625 www.anthem.com
Care*Net* – Administered by Southern Health Services, Inc.	1-800-279-1878 TTY/TDD 1-877-227-3523 Nurse Advice Line – 1-877-878-8940 www.YourCareNet.com
Optima Family Care- A Service of Sentara – Underwritten by Optima Health Plan	1-757-552-8975 or 1-800-881-2166 Nurse Advice Line – 1-800-394-2237 or 1-757-552-7250 www.Optimahealth.com
Virginia Premier Health Plan, Inc.	Tidewater – 1-757-461-0064 or 1-800-828-7989 Richmond/Central/Western Members - 804-819-5151 or 1-800-727-7536 Roanoke/Danville/Lynchburg Members - 1-540-344-8838 or 1-888-338-4579 Nurse Advice Line – 1-800-256-1982 www.vapremier.com
MEDALLION Managed Care Help Line	1-800-643-2273 TTY/TDD 1-800-643-2273 http://www.virginiamanagedcare.com/
Fee-For-Service DMAS Recipient Helpline	Eligibility - Call your local Department of Social Services Covered Services - Call DMAS Recipient Helpline: 1-804-786-6145 http://www.dmas.virginia.gov/

10. Provider Services Contact Information

Plan Name	Provider Services Phone Number
AMERIGROUP Community Care	1-800-454-3730 www.myamerigroup.com
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority)	1-800-901-0020 1-757-326-5270 www.anthem.com
Care*N*et – Administered by Southern Health Services, Inc.	1-800-449-1944 www.directprovider.com
Optima Family Care- A Service of Sentara – Underwritten by Optima Health Plan	1-757-552-7474 or 1-800-229-8822 www.Optimahealth.com
Virginia Premier Health Plan, Inc.	Tidewater - 1-800-828-7989 Richmond/Central/Western - 1-800-727-7536 Roanoke/Danville/Lynchburg - 1-888-338-4579 www.vapremier.com
MEDALLION and FFS DMAS Provider Helpline Monday through Friday from 8:30 a.m. to 4:30 p.m.	1-804- 786-6273 Richmond area and out-of-state long-distance 1-800-552-8627 All other areas (in-state long-distance, toll-free) http://www.dmas.virginia.gov/

11. Pharmacy Contact Information

Plan	Formulary	Prior Authorization
AMERIGROUP Community Care	Closed Formulary	CVS Caremark Provider Phone # 1- 800-454-3730 Provider Fax # 1-800-359-5781
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority)	Closed formulary	Providers should FAX forms to 1-800-601-4829 Retail Pharmacy Services help desk 800-662-0210 Prior Authorization 1-800-338-6180
Southern Health – Care*N*et	Closed Formulary	Pharmacy Services Help Desk 1-800-378-7040 Formulary Exception Requests Pharmacy Call Center Phone 1-877-215-4100 FAX 1-877-554-9137
Optima Family Care	Closed Formulary	Argus Health Systems 1-800-KCARGUS 1-800-522-7487 Pharmacy Department Fax 1-757-552-7516 1-800-750-9692
Virginia Premier Health Plan, Inc.	Formulary	Express Scripts 1-866-312-9065 FAX 1-800-357-9577
MEDALLION or Fee-For-Service	Formulary	First Health Services Corporation (FHSC) 1-800-932-3923 Fax 1-800-932-6651 https://virginia.fhsc.com/Pharmacy/Initiatives.asp http://www.dmas.virginia.gov/pharm-home.htm

12. Transportation Scheduling and Contact Information

Plan	Scheduling Instructions	Special Instructions
AMERIGROUP Community Care Reservations 800-894-8139 Where's My Ride 800-894-8396 Fax 866-679-6329	Members are advised to call three days before the scheduled appointment between 8 a.m. and 5:30 p.m. Monday-Friday except national holidays to make reservations for transportation services.	Operators will be available 24 hours a day, 7 days a week for immediate response to urgent requests for transportation services. If proper notice is given, bus tickets and passes will be mailed to members when requested. Gas reimbursement may be available to a friend, neighbor or relative to transport members to medical appointments.
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority) 1-877-892-3988 Available 24/7	Members are advised to call 5 days before the scheduled appointment. To allow time to mail bus tickets, 7 days is recommended. Member will be picked up by the transportation provider 1 hour before the scheduled appointment.	Special arrangements can be made for wheelchair transportation. Bus tickets are provided by mail.
Care*N*et – Southern Health 1-800-734-0430	Members are advised to call 3 business days before the scheduled appointment. The transportation provider will pick up member about 1 hour before the scheduled appointment.	Bus tickets and bus passes are available and will be mailed to members. There are also other available modes of transportation available for those members with special needs.
Optima Family Care Reservations 877-892-3986 <u>Where's my Ride?</u> Norfolk 866-886-4018 Richmond 866-660-4371 Norton 866-837-9155 Herndon 866-216-7858 Bedford 866-417-0297 Charlottesville 866-907-5191	Members are advised to call 48 hours before scheduled appointments and 5 days before routine physical appointments preferred. Member will be picked up by the transportation provider 1 hour before the scheduled appointment.	Special arrangements may be made for wheelchair and ambulance transportation. Bus tickets and bus passes are available and will be mailed to members. Discharge planners at the hospital work with case manager at the MCO for discharge transport arrangement.
VA Premier Health Plan, Inc. 800-727-7536 - Richmond/Central/Western 800-828-7989 - Tidewater 888-338-4579 – Roanoke/D'ville/L'burg	Members are advised to call 48 hours before the scheduled appointment. Member will be picked up by the transportation provider ½ to 1 hour before appointment.	Bus tickets are available by mail or an outreach worker can hand deliver to client's home. VA Premier Health Plan operates their own transportation Vans. Special arrangements can be made for wheelchair transportation.
MEDALLION and Fee-For-Service Logisticare – 1-866-386-8331 MDs, DSS, CSB and Health Departments Only – 1-866-679-6330	Transportation is available 24 hours a day, 7 days a week, holidays included. To request a trip, you or your representative can contact the LogistiCare Call Center in Norton, VA at toll free 866-386-8331. Please request your trips at least 5 days in advance unless it is an urgent trip. If you or become ill and your doctor can see you in less than five days, call the broker and request an Urgent Trip. If you will have at least three trips per week at the same time and to and from the same destination, you can request a Standing Order and avoid booking each trip individually.	All complaints from recipients and facilities should go to the "Where's My Ride?" (WMR) number at the regional office. *Region l: Norton 866-246-9979* *Region 2: Bedford 866-586-0255* *Region 3: Richmond 866-742-9758* *Region 4: Norfolk 866-966-3326* *Region 5/6: Charlottesville 866-973-3310* *Region 7: Herndon 866-707-3761*

Global Medicaid Transportation Coverage Guidelines

Emergency Ambulance Services

Emergency ambulance is a covered service. Coverage is not available for emergency ambulance transportation to treat minor abrasions, lacerations, bruises, fever, normal labor pains and other similar non-life-threatening conditions.

Non-Emergency Transportation Services

Covered non-emergency services include the following modes of transportation:

- Ambulance
- Wheelchair van
- Common carrier bus services
- Commercial taxicab services
- Stretcher Vans

Transportation is Covered When:

No other means of transportation is available to the recipient to receive services which are covered by Medicaid.

Transportation is NOT Covered for:

- Routine physicals and immunizations except to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.
- Picking up prescription drugs at the pharmacy when the prescription can be delivered or mailed. If such a service is not available, transportation may be covered.
- Picking up Women, Infants and Children (WIC) Supplemental Food Program vouchers or for certification or recertification to the WIC Program.
- Any other non-covered service, services not medically necessary, free services-services provided free to the general public, etc.

NOTE:
One escort is allowed to accompany a recipient or group of recipients who are blind, deaf, mentally ill, mentally retarded or under 21 years of age. No charge is to be made for the escort.

13. Vision Contact Information

MCO Name and Administrator	Customer Service Contact
AMERIGROUP Community Care - - Administered by Block Vision, Inc.	Members - 1-800-428-8789 Providers - 1-866-819-4298
Anthem HealthKeepers Plus - - (HealthKeepers, Peninsula, Priority) Administered by Davis Vision	1-800-901-0020
Care*N*et - - Administered by Vision Service Plan (VSP)	1-800-279-1878
Optima Family Care - - Administered by EyeMed Vision Care	1-800-881-2166
Virginia Premier Health Plan - - Administered by Vision Service Plan	1-800-828-7989 – Tidewater 1-800-727-7536 - Richmond/Central/Western 1-888-338-4579 – Roanoke/Danville/Lynchburg
MEDALLION or Fee For Service	Providers – Provider Helpline 1-804- 786-6273 Richmond area and out-of-state long-distance 1-800-552-8627 All other areas (in-state long-distance, toll-free) http://www.dmas.virginia.gov/ http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx

14. Medical and Disease Management Contacts

Plan Name	Case Management Information
AMERIGROUP Community Care	Case Management Department 1-800-964-2112
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority)	Medical Management - 1-800-533-1120 Case Management Referral Line - 1-877-332-8193 Disease Management (ConditionCare) - 1-800-445-7922
Care*N*et – Administered by Southern Health Services, Inc.	Case Management Department - 1-800-424-0077 Asthma/COPD Case Manager, Ext. 1218 Diabetes Case Manager, Ext. 1216 Complex Case Manager, Ext. 1282 Heart Failure Case Manager, Ext. 2511 Transplant Case Manager, Ext. 2406 or 1238 Social Worker, Ext. 1240
Optima Family Care- A Service of Sentara – Underwritten by Optima Health Plan	Medical Case Management Department - 1-866-503-5828
Virginia Premier Health Plan, Inc.	Medical Management Richmond/Central/Western - 1-800-727-7536 ext. 5711 - FAX – 1-804-819-5186 or 1-866-284-1057 Roanoke/Danville/Lynchburg - 1-888-338-4579 ext. 5785 FAX – 1-540-344-8007 or 1-800-827-7192 Tidewater - 1-800-828-7989 ext .2161 FAX – 1-757-466-1133 Disease Management - 1-800-243-0937 ext. 5753 FAX - 804-819-5361 Referrals/Preauthorization Tidewater/Central/Richmond/Western - 1-888-251-3063 ext. 5709 Southwestern - 1-888-338-4579 ext. 5709
MEDALLION and Fee-For-Service Virginia Medicaid Healthy Returns By: Health Management Corporation (Providers or Recipients can call)	Disease Management 1-866-836-4008 24 hours per day / 7 days per week Coronary Artery Disease Congestive Heart Failure Asthma Diabetes Chronic Obstructive Pulmonary Disease http://www.dmas.virginia.gov/dsm-home.htm

15. High Risk Maternal Infant Program Services and Contact Information

Plan	Infant Program	Services	
AMERIGROUP Community Care 7550 Teague Road, Suite 500 Hanover, MD 21076	**Taking Care of Baby and Me** 1-800-964-2112	▪ Complete initial screening. ▪ Telephonic contact ▪ Physician Communication	▪ Care Management Education ▪ Educational Mailings ▪ Prenatal & Postpartum Incentive Gift Reward
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority) 2220 Edward Holland Drive MD 62 N Richmond, VA 23230	**Future Moms** 1-800-828-5891	▪ Telephonic education, counseling and monitoring ▪ Reassessment and additional education at 28-30 weeks gestation ▪ Pregnancy related educational materials ▪ 24-hour toll free access to RN ▪ Postpartum outcomes assessment	▪ Enrollment of child in 24-month Parenting Program to provide ongoing education and support to parents ▪ Identification and intensive management for high risk pregnancies Outreach ▪ Home visiting outreach ▪ Gift bag programs
CareNet: Southern Health Services 9881 Mayland Drive Richmond, VA 23233	**Baby Matters** 1-800-975-1213, ext. 2476	▪ Patient Education ▪ Nutrition counseling ▪ Homemaker services ▪ Coordination of community resources ▪ Prenatal incentive Rewards ▪ Post-partum educational materials	▪ Telephone follow up to screen for depression ▪ Follow-up monitoring ▪ Guidance and support ▪ Telephone/mailing contacts ▪ 17P
Optima Family Care Partners In Pregnancy 4417 Corporation Lane Virginia Beach, VA 23462	**Partners in Pregnancy** 1-866-239-0618	▪ Monthly telephone calls/serial screening for risk factors ▪ Continual assessment and follow up with MD when appropriate ▪ RN OB case manager follows high-risk cases and refers to community resources as available and appropriate	▪ Home visitation through CHIP or Sentara Home care Services according to risk evaluation ▪ Regular educational and support material mailings
Virginia Premier Health Plan, Inc. 600 E. Broad Street Suite 400 Richmond, VA 23219-1800	**Healthy Heartbeats** Tidewater – 1-800-828-7989 - ext 2157 FAX - 1-757-466-1133 Roanoke/Danville/Lynchburg 1-888-338-4579 – ext. 5784 FAX - 1-800-827-7192 Richmond/Central/Western 1-800-727-7536 ext. 5710 FAX - 1-804-819-5186	▪ Initial home visit by Medical Outreach Rep with Intake Assessment ▪ Follow-up visit frequency depends on risk (minimum of once per trimester) ▪ Post partum home visit ▪ Incentive gifts at first visit and gift bag with baby items postpartum	▪ Teenager special prenatal education ▪ Printed educational materials ▪ OB classes (CBE; breast feeding; baby care) ▪ RN case management if high risk
DMAS MCH Division 600 E Broad Street Suite 1300 Richmond, VA 23219	**BabyCare*** 804-786-6134 Fax: 804-225-3961 Email: MICC@dmas.virginia.gov *For specific information on eligibility, services, forms and provider qualifications, reference the BabyCare provider manual, available at www.dmas.virginia.gov*	▪ Maternal Infant Care Coordination (MICC), a home visitation/care coordination program for pregnant women and infants up to age two who are identified as high-risk	▪ Expanded prenatal services for pregnant women including patient education classes, nutritional services, homemaker services and Substance Abuse Treatment Services (SATS)

16. Early Intervention Program and Contact Information

PLAN	PHONE/FAX
AMERIGROUP Community Care	1-800-964-2112
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority)	1-800-901-0020
CareNet/Southern Health	1-800-424-0077 ext. 1156
Optima Family Care	1-866-503-5828
Virginia Premier Health Plan, Inc.	Richmond/Central/Western - 1-800-727-7536 ext. 5711 FAX - 1-804-819-5186 Tidewater - 1-800-828-7989 ext. 2161 FAX – 1-757-466-1133 Roanoke/Danville/Lynchburg - 1-888-338-4579 ext. 5785 FAX - 1-800-827-7192
MEDALLION or Fee-For-Service	Local Inter Agency Coordinating Council for Early Intervention http://www.infantva.org/

Early Intervention (EI) Services are designed to meet the treatment needs of an infant or toddler up to age 3 with developmental delay in one or more areas of developmental delay (physical, cognitive, communication, social or emotional, or adaptive). Services are performed by EI certified providers in the child's natural environment, to the maximum extent possible. Natural environments can be the child's home or a community based setting in which children without disabilities participate. EI Treatment is provided in accordance with the child's Individualized Family Service Plan (IFSP) which addresses the developmental needs of the child while also enhancing the capacity of families to meet those developmental needs through family centered treatment.

In October, 2009, the Department, working collaboratively with the Department of Behavior Health and Developmental Services (DBHDS), implemented a restructured EI program requiring providers to be trained and certified by DBHDS, and requiring providers to bill using newly established EI specific fee-based procedures codes. The restructured EI program is designed to effectively provide the necessary EI treatment, including developmental supports, therapies and services to EI enrolled children in natural environment settings, while ensuring compliance with Federal Part C payor of last resort requirements.

The contracted MCO is not required to provide coverage for early intervention services. EI services for children who are enrolled in fee-for-service Medicaid or one of the Department's contracted MCOs are covered by the Department within the Department's coverage criteria and guidelines. EI billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website: http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx.

For information on EI Provider Certification – Contact the Infant & Toddler Connection at 804-786-3710 or visit: www.infantva.org/Contactus.htm.

For information on how to make EI service referrals, visit: http://www.infantva.org/documents/pr-Referral Guide.pdf

For information on how to enroll as a DMAS EI Provider – call 1-888-829-5373

17. Medical Services Referral and Prior Authorization (PA) Requirements

Anthem	AMERIGROUP	CareNet	Optima	Virginia Premier	MEDALLION (and FFS)
PCP Referral Required? No referral needed for an in-network specialist. Prior Authorization All services other than routine x-rays, mammograms, limited diagnostic testing and gynecological visits, PCP visits and participating specialist visits. **Anthem prior authorization** 1-800-553-1120	PCP Referral Required? No referral needed for an in-network specialist. Prior Authorization Inpatient admission and services, skilled nursing facility, chemotherapy, cardiac rehab, Non-routine diagnostic testing (CAT, MRA,MRI, PET scans, nuclear cardiology), genetic testing, DME, home healthcare, hospice, pain management, selected pharmacy, podiatry, PT/OT/Speech therapy, non-par/out of area services, chiropractic, dermatology, ENT, gastroenterology, neurology, ophthalmology, oromaxillofacial plastic/cosmetic services, and inpatient and outpatient mental health and substance abuse services. For procedure specific rules, please visit www.amerigroupcorp.com/providers.	PCP Referral Required? No referral needed for an in-network specialist. Prior Authorization Cardiac rehabilitation, DEXA scans, clinical trials, DME, home health care or services, hospital observation stays, inpatient hospital care, MRI, MRA and PET Scans, outpatient surgery, pain management services/programs, polysomnograms, services performed by a non-participating provider, physical, occupational and speech therapy, and all inpatient and outpatient mental health and substance abuse services, AICD, bi-ventricular pacemaker, dental accidents, injectable drugs and neuropsychological testing, insulin pump and supplies, pulmonary rehabilitation, CT Scans, Genetic Testing, Intensity-modulated Radiation Therapy, Non-Implanted Prosthetic Devices, Nuclear Imaging performed in conjunction with exercise stress testing, Nutritional Formulas and Supplements, Oral Surgery, Transplant Consultations, evaluations, and testing//transplant procedures.	PCP Referral Required? No referral needed for an in-network specialist. Prior Authorization Non-formulary drugs, inpatient care, outpatient and surgery services including some diagnostic testing, inpatient mental health and substance abuse, DME (including hearing aids), early intervention, home health, hospice care, orthopedic and prosthetic appliances, physical therapy, occupational therapy and speech therapy, private duty and skilled nursing.	PCP Referral Required? No referral needed for an in-network specialist. Prior Authorization All inpatient and outpatient hospital services, all out of network services, DME, home health, PT/OT/ST, prosthetics and orthotics, skilled nursing.	PCP Referral Required? Reference the MEDALLION section of this guide for PCP referral requirements. Prior Authorization http://www.dmas.virginia.gov/pr-prior_authorization.htm KePRO – All inpatient Treatment Stays, except for normal newborn-normal nursery, normal vaginal deliveries, and Cesarean section deliveries billed with ICD-9 CM Procedure codes 74.1-74.9 with a length of stay of 5 days or less; PT/OT/ST over the 5 visit per fiscal year limit; Non-emergent MRI, PET, and CAT scans, Home Health Skilled Nursing and PT/OT/and ST over the 5 visit per fiscal year limit; Outpatient Psychiatric visits over the 26 annual limitation in the first year of treatment and all visits each year thereafter; Treatment Foster Care Case Management, Psychiatric Residential Treatment, Intensive In-Home Services (under age 21) beyond 12 weeks of treatment; DME – per the DME Manual Appendix B; Home and Community Based Waiver Services – some handled by KePRO, some handled by DMAS; some handled by DMHMRSAS. Reference: http://www.dmas.virginia.gov/downloads/pdfs/pr-pa_Waiver_Matrix.pdf **KEPRO Information** **iExchange: http://dmas.kepro.org/** **Toll Free Phone:** 1-888-827-2884 **Local Phone**: (804) 622-8900 **Fax:** 1-877-652-9329 **Mail:** 2810 N. Parham Road, Suite 305, Richmond, VA 23294 **Other Provider Issues:** ProviderIssues@kepro.org *FFS PA Continued Below*

Medicaid MEDALLION and Fee For Service (FFS) Prior Authorization Requirements Continued -

DMAS Medical Support - DMAS continues to handle prior authorization in-house for: out of state placement, organ transplants, certain medical/surgical procedures, and prostheses. For more information, refer to the DMAS website at: http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/phy/appendixD_phy.pdf. Send requests for these procedures to: Moses N. Adiele, M.D., Medical Director, DMAS Medical Support Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219 Phone - 804-786-8056 Fax - 804-786-0414

Hospice Services are handled by the Department of Medical Assistance Services Facility and Home Based Services Unit. Refer to Hospice Manual for admission criteria http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/hspc/chapterVI_hspc.pdf ; FAX requests to DMAS FHBSU (804) 371-4986

18. Authorization Process for PT, OT and Speech Therapies

MCO	PCP REFERRAL REQUIRED	PRIOR AUTHORIZATION REQUIRED	UTILIZATION REVIEW PROCESS
Southern Health - Care*N*et	No	Yes – for all services after the initial evaluation	Therapist submits plan of care for authorization of services. Utilization review frequently for continued authorization of visits.
Optima Family Care	No	Yes – for all services after initial evaluation.	Therapist submits plan of care for authorization of services. Utilization review frequently for continued authorization of visits.
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority)	No	Yes	Physician or therapist request prior auth for evaluation. Once evaluation is done and medical necessity review performed, services will be authorized for up to 12 visits. Updates will be required if additional visits are required.
Virginia Premier Health Plan, Inc.	No	Yes	Therapist requests prior authorization for evaluation and given 4 visits. If additional visits needed, therapist will send Plan of Care and auth given up to benefit limit.
AMERIGROUP Community Care	No	Yes – for all services after initial evaluation. All children of school age should be evaluated for school-based Speech Therapy prior to preauthorization at a non-school-based location.	Preauthorization may be either called in (800-454-3730) or faxed (800-964-3627).
MEDALLION and Fee For Service	Yes	Yes – for all services after the 5 visit limit per fiscal year (July 1 – June 30th)	Send preauthorization requests to the DMAS Preauthorization Contractor (KePRO). Submit requests via iExchange @ http://dmas.kepro.org/ or call 804-622-8900 or 1-888-827-2884 Or FAX – 1-877-6529329

19. MCOs Honoring Prior Authorizations

- Contracts require the MCO to honor all services prior authorized by DMAS or another MCO.

- If a recipient was receiving home health visits, for example, this service should continue without interruption. This may allow the MCO to review the service for medical necessity within the utilization review process to determine continued needs and to determine if the criteria for medical necessity are being met.

- MCOs may also change the provider to one of their own contracted providers on a timely basis so as not to delay or stop the continuity of care being provided.

- Children covered by a MCO under Medallion II who have services prior authorized for coverage under the Medallion II MCO, but then become covered by that same plan under FAMIS, can receive the authorized service, as long as the service is covered by FAMIS.

20. Behavioral Health Services Referral/Authorization and Contact Information

Plan	Referral/Authorization Required?	Phone/FAX
AMERIGROUP Community Care	No PCP referral necessary	1-800-454-3730
Anthem HealthKeepers Plus (HealthKeepers, Peninsula, Priority) (Anthem Behavioral Health)	No PCP referral required No Prior Authorization required if provider is participating with HealthKeepers Plus	1-800-991-6045
Care*N*et/Southern Health	No PCP referral necessary	1-800-975-8919
Optima Family Care (Optima Behavioral Health)	No PCP referral required Prior Authorization by member phone call to Optima good for up to five visits For addition visits past five, Psych M.D. must submit a plan of care to Optima	1-757-552-7174 or 1-800-648-8420
Virginia Premier Health Plan, Inc.	No PCP referral required for network providers Mental Health provider must formulate an Outpatient Treatment Report for visits past three (3) and an Outpatient Treatment Report for visits past 26 per year.	**Richmond/ Central/ Western** Referral Coordinator – 1-888-251-3063 Behavioral Health Case Manager 1-800-727-7536 ext. 5712 **Roanoke/Danville/Lynchburg** Referral Coordinator – 1-888-338-4579 Behavioral Health Case Manager 1-888-338-4579 ext. 5786 **Tidewater** Referral Coordinator – 1-800-828-7989 Behavioral Health Case Manager 1-800-828-7989 ext. 2162
MEDALLION or Fee For Service	No PCP referral required for network providers Outpatient Treatment - 26 visits within the first year of treatment is allowed without prior authorization (PA) - extensions require authorization. Each year thereafter, 26 visits are allowed with PA. (Unlimited coverage is available with PA for children under age 21.) DMAS contracts with KePRO to handle PA of behavioral health services.	**KEPRO CONTACT INFORMATION** **iExchange: http://dmas.kepro.org/** **Toll Free Phone: 888-VAPAUTH (888-827-2884)** **Local Phone: (804) 622-8900** **Fax: 877-OKBYFAX (877-652-9329)** **Mail: 2810 N.** Parham Road, Suite 305, Richmond, VA 23294

21. Mental Health and Substance Abuse Treatment Services

The MCO is responsible for coverage of outpatient mental health and outpatient substance abuse services to the extent that they are at least equal in amount, duration, and scope as described in the Virginia Administrative Code at 12VAC30-50-140/141, 12VAC30-50-150/151, and 12VAC30-50-181.

Outpatient Mental Health Services - Covered by Medallion II MCOs

Psychiatric Diagnostic Examination
Individual Medical Psychotherapy
Family Medical Psychotherapy
Electro Convulsive Therapy
Group Medical Psychotherapy
Psychological/Neuropsychological Testing
Pharmacological Management

Outpatient Substance Abuse Services - Covered by Medallion II MCOs

Assessment and Evaluation; Outpatient Therapy (individual, family, and group); and Pharmacological Management

Community Mental Health and Substance Abuse Rehabilitation Services - Carved-Out of the MCO Contracts

These mental health and substance abuse treatment services are rendered by public and private providers and DMAS is always the payer source. The MCO must cover transportation to/from Medicaid covered Community Rehabilitation Services and Medicaid covered medications.

Mental Health Community Services:

Intensive In-Home Services for Children and Adolescents
Therapeutic Day Treatment for Children and Adolescents
Day Treatment/Partial Hospitalization
Psychosocial Rehabilitation
Crisis Intervention
Intensive Community Treatment
Crisis Stabilization Services
Mental Health Support Services
Case Management

Mental Retardation Community Services:

Case Management Services

Substance Abuse Treatment Services:

Crisis Intervention
Intensive Outpatient
Day Treatment
Opioid Treatment
Case Management
Residential Treatment

Treatment Foster Care Case Management (TFC - CM) and Residential Treatment (RT) Services

Children under age 21 enrolled in DMAS authorized TFC-CM and RT programs will be temporarily excluded from MCO enrollment. Reference the DMAS Psychiatric Services Manual, Chapter IV for TFC and RT coverage criteria. Contact the DMAS Preauthorization Contractor, KePRO 888-827-2884 for authorization of TFC and RT services for all Medicaid (including Medicaid MCO) recipients.

22. Medicaid Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)

What is EPSDT?

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) is a comprehensive and preventive child health program for individuals under the age of 21 that is required by the federal government to be a part of every state's Medicaid package.

Under the Social Security Act Section 1905(r)(5), states are required to provide any medically necessary health care services listed at section 1905 (a) of the Social Security Act to correct and/or ameliorate physical and mental conditions discovered during screening services even if the service is not included under the state's Medicaid plan. This includes periodic screening, vision, dental and hearing services.

Virginia's EPSDT program goals are to keep children as healthy as possible by:

- Assuring that health concerns are diagnosed as early as possible,
- Assuring that treatment is provided before problems become complex, and
- Assuring that medically justified services are provided to treat or correct identified problems

Who is eligible for EPSDT Services?

- Children under the age of 21 who receive Medicaid through Medicaid/FAMIS Plus or a MCO
- FAMIS children who are not enrolled with a Managed Care Organization
- MCO enrolled FAMIS children are <u>not</u> eligible for the full scope of EPSDT services

EPSDT screenings are conducted by physicians, physician assistants or certified nurse practitioners and can occur during the following:

- Initial Screening – This is a check up provided when the child enters Medicaid.
- Periodic Screening – Check up that should occur at regular intervals. Virginia uses the American Academy of Pediatrics and Bright Futures guidelines to develop the Virginia EPSDT periodicity schedule.
- Inter-periodic Screening – unscheduled check-up or problem focused assessment that can happen at any time because of illness or a change in condition. Any caregiver or professional who interacts with the EPSDT enrollee may request the screening.

What are the required components in EPSDT screenings?

- Comprehensive unclothed physical exam
- Patient and family medical history including identifying risk factors for health and mental health status
- Developmental, Vision and Hearing Screening
- Preventive laboratory services including
    - Mandatory Lead testing at 12 months and 24 months
- Age appropriate Immunizations
- Referral to a dentist at age 3
- Age appropriate anticipatory guidance/health counseling
- Referrals for medically necessary health and mental health treatment

All requests for EPSDT treatment services must:

- Be deemed medically necessary to correct or ameliorate a health or mental health condition, and
- Have the need for specialist referral or treatment documented during an EPSDT screening.

Services that are considered experimental or investigational are not covered

EPSDT Specialized Services are medically necessary treatment services that are not a routinely covered service through Virginia Medicaid. All EPSDT "specialized services" must be a service that is allowed by the Centers for Medicare and Medicaid Services (CMS). The allowable treatment services are defined in the United States Code in 42 U.S.C. sec 1396d (r) (5)

The most frequently provided EPSDT specialized services are:

- Residential Substance Abuse Treatment Services
- Specialized Behavioral Rehabilitation Services
- Hearing Aids
- Assistive Technology
- Personal Care
- Private Duty Nursing

DMAS Contact: Brian.Campbell@dmas.virginia.gov or 804-786-6134.

Web-based continuing education modules on current Bright Futures and EPSDT standards are accessible at www.vcu-cme.org/bf.

EPSDT Screening Procedure Codes

DESCRIPTION	Age	CPT Code
INITIAL SCREENINGS		
NEWBORN CARE (outpatient)	Normal newborn care	99432
NEW PATIENT	less than 1 year of age	99381*
NEW PATIENT	1-4 years of age	99382*++
NEW PATIENT	5-11 years of age	99383*
NEW PATIENT	12-17 years of age	99384*
NEW PATIENT	18-20 years of age	99385*
PERIODIC SCREENINGS		
ESTABLISHED PATIENT	less than 1 year of age	99391*
ESTABLISHED PATIENT	1-4 years of age	99392*++
ESTABLISHED PATIENT	5-11 years of age	99393*
ESTABLISHED PATIENT	12-17 years of age	99394*
ESTABLISHED PATIENT	18-20 years of age	99395*
DEVELOPMENTAL TESTING (Instrument, Interpretation/Report)		
SCREENING	0-20 years of age	96110
EXTENDED	0-20 years of age	96111
LEAD TESTING (Mandatory at 12 mos. and 24 mos. of age)		
TESTING (by Lab)	0-20 years of age	83655
VENOUS SAMPLE	0-20 years of age	36415
CAPILLARY SAMPLE	0-20 years of age	36416
SPECIMEN HANDLING	0-20 years of age	99000
VISION SCREENING		
VISION	3-20 years of age	99173
HEARING SCREENING		
HEARING	0-20 years of age	92551

Use of the appropriate CPT modifiers on the claim should be indicated as previously defined within this memo or CPT.

**Use appropriate Immunization Codes for scheduled immunizations*
++ Lead Testing required at 12 and 24 months

23. Virginia Vaccines For Children (VVFC) Program

Virginia Vaccines For Children provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. MEDALLION PCPs and some Medallion II PCPs participate in Virginia Vaccines For Children.

Medicaid, FAMIS Plus (Children's Medicaid), MEDALLION: Age 0-18----eligible for VVFC

- DMAS will not reimburse the acquisition cost for vaccines covered under VVFC.
- DMAS will reimburse an appropriate office visit or preventive medicine fee.
- DMAS will reimburse the provider an administration fee ($11.00) for each vaccine.

Age 19-20---not eligible for VVFC

- DMAS will reimburse the provider the acquisition cost.
- DMAS will reimburse an appropriate office visit or preventive medicine fee.
- DMAS will **not** reimburse an administration fee.

FAMIS:

Age 0-18---not eligible for VVFC

Children enrolled in FAMIS **are not eligible** for VFC. They are not Medicaid.

- DMAS will reimburse the provider the acquisition cost.
- DMAS will reimburse an appropriate office visit fee.
- DMAS will reimburse an administration fee ($11.00).

To ensure proper reimbursement by DMAS:

- Use the Evaluation and Management CPT code for the appropriate office visit or Preventive Medicine Service (EPSDT Screening Procedure Code).
- Always bill your usual and customary fee.
- Use the CPT code for the immunization. Bill the usual and customary cost plus $11.00.
- Complete 11d appropriately.
- The DMAS claims system will read the recipient/FAMIS enrollee file and pay accordingly.

Medallion II:

Medicaid and FAMIS clients enrolled in a Virginia Medicaid contracted Managed Care Organization (MCO):

Client eligibility for Virginia Vaccines For Children is the same as above.
Providers participating in Medallion II should contact their MCO for billing instructions.

Virginia Vaccines For Children:

VVFC covers children who are less than 19 years of age and meet one of the following criteria:

- Medicaid enrolled
- Uninsured (no health insurance)
- American Indian or Alaskan Native
- Under insured (commercial insurance coverage does not include vaccines). *These children must go to a Federally Qualified Health Center, Rural Health Center or local Health Department.*

For more information on VVFC call 800-568-1929 or 804-864-8055